



## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor's Name and Address:

Comprehensive Pain Management  
5734 Spohn Drive, Ste. A  
Corpus Christi, TX 78414

MFDR Tracking #: M4-08-3653-01

Respondent Name and Box #:

Liberty Mutual Insurance Co.  
Rep. Box #: 28

### PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary listed on the Table of Disputed Services: "Physician saw the patient for an office visit for his compensable injury. According to TWCC Fast Facts, if the injury is compensable, the carrier is liable for all reasonable and necessary medical costs of health care to treat the compensable injury. Note: Patient was referred to Dr. Potter. Dr. Potter is not the claimant's treating physician and does not need to be one in order to render medical services to claimant."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - \$000.00
3. CMS 1500s
4. EOBs

### PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: A response to the Request for Medical Dispute Resolution was not received.

Principle Documentation:

1. N/A

### PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
09/13/07	CPT Code 99213 (56.03 x 125%)	X049	1 - 3	\$70.04
<b>Total Due:</b>				\$70.04

### PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "X049 - Not treating doctor."
2. According to 28 Texas Administrative Code Section 180.22(c)(1) states that except in the case of an emergency the treating doctor may approve or recommend all health care rendered to the claimant including, but not limited to, medically reasonable and necessary treatment or evaluation provided through referrals to consulting and referral doctors. The CMS-1500, Box 17, names Dr. Michael G. Winnie as the referring provider. Therefore, per 28 Texas Administrative Code Section 134.202(b) and (c)(1) reimbursement in the amount of \$70.04 is recommended.

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

3. Per review of Box 32 on CMS-1500, zip code 78414 is located in Nueces County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

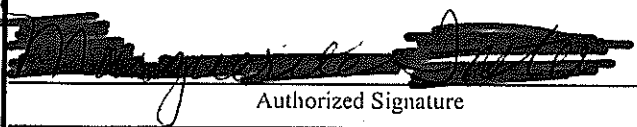
#### PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311  
28 Texas Administrative Code Section. 180.22, 134.1, Section. 134.202  
Texas Government Code, Chapter 2001, Subchapter G

#### PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of \$70.04 plus applicable accrued interest per Division Rule 134.130.

#### ORDER:

  
Authorized Signature

  
Medical Fee Dispute Resolution Officer

3/14/08  
Date

#### PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

[REDACTED]

[REDACTED]